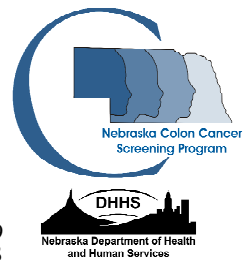


# Enrollment Form for Men & Women 50+



1. **ALL QUESTIONS MUST BE ANSWERED.** Please print. Fill in as much as possible.
2. **Read and Sign the back of this page.**
3. **Return this form to the Nebraska Colon Cancer Screening Program.**

Version October 2009  
SIG-WEB



<b>First Name</b>		<b>Middle Initial</b>	<b>Last Name</b>		<b>Maiden Name</b> <i>(if applicable)</i>		
<b>Birthdate</b> month / day / year		<b>Age</b>	<b>Gender</b> M / F	<b>Social Security #</b>			
<b>Address</b>			<b>City</b>	<b>County</b>	<b>State</b>	<b>Zip</b>	
<b>Home/Cell Phone</b> <i>circle one</i> ( )		<b>Work Phone</b> ( )		<b>How did you hear about the program?</b> <input type="checkbox"/> Doctor/Clinic <input type="checkbox"/> Family/Friends <input type="checkbox"/> Newspaper/radio/TV <input type="checkbox"/> Agency <input type="checkbox"/> Self-referral <input type="checkbox"/> Outreach Worker <input type="checkbox"/> Other _____			
<b>Contact person:</b> _____ <i>(in case we can't reach you)</i> <b>Relationship:</b> _____ <b>Phone:</b> ( ) _____ <b>Address:</b> _____ <b>City:</b> _____ <b>State:</b> _____ <b>Zip:</b> _____				<b>Are you of Hispanic/Latina/Latino origin?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Country of origin</b> _____ <b>What is your primary language?</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____			
<b>What race or ethnicity are you?</b> <input type="checkbox"/> American Indian <input type="checkbox"/> Mexican American <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other _____				<b>Highest grade in school you completed:</b> <i>circle one</i> 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+			
<i>I will be required to show proof that my income is within the NCP income guidelines when I am contacted by the NCP staff.          If I am found to be over the income guidelines, I will be responsible for my bills.</i>							
<b>What is your household income before taxes?</b> <b>Yearly Income:</b> \$ _____				<b>How many people live on this income?</b> _____			
<b>Do you have:</b> <input type="checkbox"/> Medicare Part A and B <input type="checkbox"/> Medicare Part A only <input type="checkbox"/> Medicaid (full coverage for self) <input type="checkbox"/> None/No Coverage <input type="checkbox"/> Private Insurance with or without Medicaid Supplement <i>(please list)</i> _____							
<b>Is your insurance an HMO?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>An HMO is a health maintenance organization.</i>							
<b>Family History:</b> How many 1st degree relatives, excluding yourself, <i>(parents, brothers, sisters, children)</i> have been told they have colon cancer or rectal cancer? <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3+ <input type="checkbox"/> Don't Know How many of those family members with colon cancer were under the age of 60? <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3+ <input type="checkbox"/> Don't Know  How many 1st degree relatives, excluding yourself, <i>(parents, brothers, sisters, children)</i> have been told they have polyps in the colon? <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3+ <input type="checkbox"/> Don't Know How many of those family members with polyps were under the age of 50? <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3+ <input type="checkbox"/> Don't Know  How many 1st degree relatives, excluding yourself, <i>(parents, brothers, sisters, children)</i> have been told they have other types of cancer? <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3+ <input type="checkbox"/> Don't Know What kind of cancer did they have? _____				<b>Personal History:</b> <b>Have you ever had any of the following tests?:</b> <b>Fecal Occult Blood Test (FOBT)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know   Date ____/____/____ What did your doctor say about your exam? _____ Was your exam: <input type="checkbox"/> Positive <input type="checkbox"/> Negative  <b>Colonoscopy</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know   Date ____/____/____ What did your doctor say about your exam? _____ Were there polyps removed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know  <b>Sigmoidoscopy</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know   Date ____/____/____ What did your doctor say about your exam? _____ Were there polyps removed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know  <b>Double Contrast Barium Enema (DCBE)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know   Date ____/____/____ What did your doctor say about your exam? _____			

**MUST COMPLETE AND SIGN BACK** ➡ ➡ ➡ ➡

Mailing Address: Nebraska Colon Cancer Screening Program -301 Centennial Mall South, P.O. Box 94817-Lincoln, NE 68509-4817

# Nebraska Colon Cancer Screening Program Enrollment Form *(continued)*

## Personal History: *(continued)*

Have you ever been told by a doctor, nurse, or other health professional that you have had:

Crohn's Disease

☐ Yes ☐ No ☐ Don't Know

Familial Adenomatous Polyposis (FAP)

☐ Yes ☐ No ☐ Don't Know

Hereditary Non Polyposis Colorectal Cancer (HNPCC)

☐ Yes ☐ No ☐ Don't Know

Inflammatory Bowel Disease (IBD)

☐ Yes ☐ No ☐ Don't Know

Ulcerative Colitis

☐ Yes ☐ No ☐ Don't Know

Are you currently under a doctor's care for any of the above conditions?

☐ Yes ☐ No ☐ Don't Know

Within the last **30 days** have you had bleeding from the rectum?

☐ Yes ☐ No ☐ Don't Know

What did your doctor say about your rectal bleeding? \_\_\_\_\_

Have you ever been told that you have had polyps in the colon?

☐ Yes ☐ No ☐ Don't Know

What type of polyps did you have? \_\_\_\_\_

How many polyps did you have? \_\_\_\_\_

Have you ever been told you have had colon or rectal cancer?

☐ Yes ☐ No ☐ Don't Know

If yes, when were you diagnosed? \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please tell us who your primary care doctor is (name of doctor):** \_\_\_\_\_

Name of clinic: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

- I want to be a part of the Nebraska Colon Cancer Screening Program (NCP). I understand that I must be 50 years of age or older and fall within the income guidelines in order to be eligible for enrollment. I also understand that I need to complete an enrollment form every year in order to participate in the NCP.
- If I am under 50 years of age, I know I **cannot** be a part of the NCP (*there are no exceptions*).
- I understand that the NCP will look at my health history and tell me what colon cancer screening test is best for me if I am eligible to participate.
- Based on my health history, I may receive screening and/or health education materials. I know that if I move without giving my mailing address to NCP, I will not get reminders about screening.
- Based upon my health history and what type of test is best for me, I know that the NCP may provide me with a Fecal Occult Blood Test (FOBT) kit and/or assist me in scheduling a colonoscopy. If I am enrolled in the program and receive an FOBT from the program and have a positive test, it may be followed up with a colonoscopy.
  - If I receive a colonoscopy through the NCP I understand that I will be asked to pay 10% of the cost.
  - I understand that my payments will help others with colonoscopy costs through the NCP.
- I have talked with my healthcare provider about the screening test(s) and understand possible side effects or discomforts.
- I have talked with the clinic about how I am going to pay for any tests or services that are not paid by the NCP.
- I understand that the NCP does not pay for treatment if diagnosed with colon cancer. NCP staff will assist me in finding the most appropriate treatment resources.
- My doctor, laboratory, clinic, radiology unit, and/or hospital can give the results of my colorectal screening, diagnostic tests, and/or treatment services to the NCP.
- To assist me in making the best healthcare decisions, NCP may share clinical and other healthcare information including lab results and health history with my healthcare providers.
- I understand that I need to identify a primary care doctor on my form. The NCP may follow up with my primary care doctor if my past medical records need to be reviewed to determine the best colon cancer screening for me. I accept responsibility for following through on any advice my doctor may give me.
- My name, address, and/or other personal information will be used only by the NCP. It may be used to let me know when I need follow up exams. This information may be shared with other organizations as required to locate treatment resources.
- Other information may be used for studies approved by the NCP and/or The Centers for Disease Control and Prevention (CDC) for use by outside researchers to learn more about colon health. These studies will not use my name or personal information.

**The Nebraska Colon Cancer Screening Program cannot pay for your services unless one of the 2 boxes below is checked.**

**ONE of the boxes below MUST be checked:**

❖ For the purpose of complying with Neb. Rev. Stat. §§4-108 through 4-114, I attest as follows:

☐ I am a citizen of the United States.

OR

☐ I am a qualified alien under the federal Immigration and Nationality Act, my immigration status and alien number are as follows: \_\_\_\_\_, and I agree to provide a copy of my USCIS documentation upon request.

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

Signature

Date of Signature

Please Print Name

Date of Birth